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Access to Health Services for Vulnerable Populations

The articles in this issue of the Health Care Financing Review *focus on access issues for vulnerable subsets of the Medicare and Medicaid populations. Following are the abstracts for articles included in this issue. The* Review *may be ordered from the U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. A one-year subscription is $30.00; single issues are $19.00. Click here to see a subscription form if you are using the Acrobat Amber™ Plug-In. For information on submitting articles to the* Review*, contact Linda Wolf, Editor-in-Chief, at (410) 786-6572 or by e-mail LWolf@hcfa.gov.* ***Statements contained in* Review *articles are solely those of the authors and do not express any endorsement by the Health Care Financing Administration.***

Overview

Renee Mentnech, M.S.

This overview discusses articles published in this issue of the *Health Care Financing Review*, entitled "Access to Health Services for Vulnerable Populations." These articles focus on the following topics: access to Medicaid for pregnant women, access measures by health status, racial access questions, end stage renal disease (ESRD) patients, other special populations, and the effects of physician payment reform.

Medicaid and Pregnant Women: Who is Being Enrolled and When

Marilyn Rymer Ellwood, M.S.W., and Genevieve Kenney, Ph.D.

Medicaid eligibility expansions and improved enrollment procedures for pregnant women during the late 1980s are examined in this article. Results show that the number of births financed by Medicaid has increased dramatically, and that women are enrolling earlier in the course of pregnancy. Nevertheless, problems continue to exist. If substantial numbers of women continue to enroll late in pregnancy, the expansions may not promote significantly earlier use of prenatal care.

Variations in Medicare Access and Satisfaction by Health Status: 1991-93

Margo L. Rosenbach, Ph.D., Killard W. Adamache, Ph.D., and Rezaul K. Khandker, Ph.D.

This article examines Medicare access, use, and satisfaction before and after implementation of the Medicare Fee Schedule (MFS), based on 3 years of data from the Medicare Current Beneficiary Survey (MCBS). Descriptive and multivariate analysis revealed that access has not deteriorated from 1991 to 1993; Medicare beneficiaries are reporting increased satisfaction—especially with the costs of care—as well as reporting fewer barriers to care. Moreover, the gaps in levels of satisfaction and frequency of perceived barriers have narrowed among those in better and poorer health, suggesting that the program has become more equitable over time.

An Analysis of Utilization and Access From the NHIS: 1984-92

Renee Mentnech, M.S., William Ross, Ph.D., Young Park, M.A., and Suzanne Benner

While the aged as a group have better access to health care since the inception of Medicare, there are subsets of the population that are still vulnerable to large out-of-pocket expenses. The focus of this analysis is on those segments of the Medicare population which are particularly vulnerable to access problems due to their personal characteristics. In particular, using data from the National Health Interview Survey (NHIS), this article will focus on the simultaneous influence of personal characteristics, such as insurance status, income, health status, and race on the on the use of physician services by the elderly population.

Black-White Treatment Differences in Acute Myocardial Infarction

Janet B. Mitchell, Ph.D., and Rezaul K. Khandker, Ph.D.

Previous research has documented that black patients with acute myocardial infarction (AMI) are significantly less likely than white patients to receive cardiac procedures. This article seeks to expand this research by: controlling for the limited ability of low-income elderly to pay for care; and adjusting for the impact of differential mortality. We selected a sample of 18,202 Medicare beneficiaries admitted during 1992 with AMI, and followed them for 90 days. Even after adjusting for other factors, black patients with AMI were less likely to undergo cardiac catheterization, and if catheterized, less likely to receive a revascularization procedure.

Health Care Use by Hispanic Adults: Financial Vs. Non-Financial Determinants

Claudia L. Schur, Ph.D., Leigh Ann Albers, M.A., and Marc L. Berk, Ph.D.

The purpose of this article is to assess the relative effects of financial and cultural factors, namely language spoken, on health care use by Hispanic adults. Using a national sample, we examine the determinants of having a usual source of care (USOC), use of physician visits, and likelihood of having blood pressure checked. Multivariate analysis reveals the following: Monolingual Spanish speakers were not significantly different from English speakers for the three dependent variables; having private insurance or Medicaid was positively related to all three dependent variables. We conclude that financial factors—primarily insurance—remain as the paramount barriers to care.

Racial Differences in Access to Kidney Transplantation

Paul W. Eggers, Ph.D.

Previous work has documented large differences between black and white populations in overall kidney transplantation rates and in transplantation waiting times. This article examines access to transplantation using three measures: time from renal failure to transplant; time from renal failure to wait listing; and time from wait listing to transplantation. This study concludes the following: First, no matter what measure of transplant access is used, black end stage renal disease (ESRD) beneficiaries fare worse than white, Asian-American, or Native American beneficiaries. Second, because the rate of renal failure exceeds the number of cadaver organs, access to kidney transplantation will deteriorate in future years for all races.

Provision of Home Dialysis by Freestanding Renal Dialysis Facilities

Michael Kendix, Ph.D.

This article explores home dialysis provision among freestanding renal facilities by examining whether they provide continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), and home hemodialysis. These modalities require fewer visits to a dialysis center, which may be beneficial for patients living long distances from facilities. A negative association was found between the number of facilities per square mile and the probability of provision of the home modalities. Secondly, facilities with a higher percent of black patients were less likely to provide the home modalities. Thirdly, facilities with larger numbers of patients were more likely to provide the home modalities.

Excluded From Universal Coverage: ESRD Patients Not Covered by Medicare

Mae Thamer, Ph.D., Nancy F. Ray, M.S., Christian Richard, M.S., Joel W. Greer, Ph.D., Brian C. Pearson, and Dennis J. Cotter, M.E.

Medicaid is believed to serve as the major insurer for end stage renal disease (ESRD) patients who are ineligible for Medicare coverage. Demographics, receipt of dialysis services, and costs of Medicaid-only populations were compared with Medicare ESRD populations in California, Georgia, and

Michigan. Notable differences in patient demographics, dialysis practice patterns, and inpatient health resource utilization between the Medicaid and Medicare ESRD populations were observed. Medicaid expenditures for Medicare-ineligible ESRD patients were considerable: in 1991, California spent $46.4 million for 1,239 ESRD patients; Georgia and Michigan each spent nearly $5 million for approximately 140 ESRD patients.

Access and Satisfaction Within the Disabled Medicare Population

Margo L. Rosenbach, Ph.D.

Little is known about variations in the levels of access and satisfaction within the disabled Medicare population. Based on the Medicare Current Beneficiary Survey (MCBS), beneficiaries under 65 years of age were classified by original reason for disability (mental versus physical). Those with a mental disability were less likely to have a private physician as a usual source; were less satisfied with the overall quality of care, availability of after-hours care, followup care, and coordination of care; and were more likely to report unmet need, owing in large part to supply barriers. Implications for the current delivery system and for design of managed care programs are discussed.

Participation in the Qualified Medicare Beneficiary Program

Peter J. Neumann, Sc.D., Mimi D. Bernardin, M.S.P.H., William N. Evans, Ph.D., and Ellen J. Bayer

This article has three objectives: to estimate how many eligible elderly beneficiaries are participating in the Qualified Medicare Beneficiary (QMB) program; to determine the characteristics of participating and non-participating eligibles; and to identify the most significant barriers to program participation. We used data from the Medicare Current Beneficiary Survey (MCBS) and the Medicare Buy-In file. We found that 41 percent of QMB eligibles are enrolled in the program; participation is higher for poor and less educated beneficiaries, those in poorer health, rural residents, African-Americans, and Hispanics. Finally, we found that, in general, eligible beneficiaries are ill-informed about the program.

Medicare Physician Payment Reform: Its Effect on Access to Care

Thomas W. Reilly, Ph.D.

This study analyzed a specific indicator condition, congestive heart failure (CHF), to see if there is evidence that physician payment reform (PPR) has had an effect on access to care for Medicare beneficiaries. If there was a decrease in access to ambulatory care services associated with PPR, one would expect to see an increase in hospitalizations for CHF in the period after PPR was implemented. This analysis examined the trend in rates of hospitalization for CHF for the overall Medicare population and for selected vulnerable subgroups. No significant discontinuity was found in hospitalizations for CHF with the implementation of PPR.

Access to Care Under Physician Payment Reform: A Physician-Based Analysis

Ann Meadow, Sc.D.

This article reports physician-based measures of access to care during the 3 years surrounding the 1989 physician payment reforms. Analysis was facilitated by a new system of physician identifiers in Medicare claims. Access measures include caseload per physician and related measures of the demographic composition of physicians' clientele, the proportion of physicians performing surgical and other procedures, and the assignment rate. The caseload and assignment measures were stable or improving over time, suggesting that reforms did not harm access. Procedure performance rates tended to decline between 1992 and 1993, but reductions were inversely related to the estimated fee changes, and several may be explainable by other factors.

DataView: Medicare Spending by State: The Border-Crossing Adjustment

Joy Basu, Helen C. Lazenby, and Katharine R. Levit

As the first step in a pioneering effort by the Health Care Financing Administration (HCFA) to measure interstate border crossing for services used by both Medicare and non-Medicare beneficiaries, the authors study the spending behavior of Medicare beneficiaries for 10 Medicare-covered services. Based on interstate flow-of-expenditure data developed for calendar year 1991, the authors analyze the spending patterns of State residents by studying the inflow and outflow rates and the net flow ratios of expenditures incurred by Medicare patients. The report also provides per capita expenditure estimates with residence-based adjustments and evaluates the impact of the border-crossing adjustment for individual services and States.

MCBS Highlights: Access to Physicians

Mary Hogan, Franklin J. Eppig, J.D., and Daniel R. Waldo, M.A.

The Medicare Current Beneficiary Survey (MCBS) is a powerful tool for analyzing enrollees' access to medical care. Based on a stratified random sample, we can derive information about the health care use, expenditure, and financing of Medicare's 36 million enrollees. We can also learn about those enrollees' health status, living arrangements, and access to and satisfaction with care. In the charts that follow, we have presented some findings on how long it takes enrollees to get an appointment with a provider, how they get to the provider's office, and how long their wait is when they get there.